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Operations Research on ESP Delivery and Community Clinics in Bangladesh

Operational Guidelines for Management of Community Clinics by Community Groups: A Study on Perspectives of Stakeholders

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Glossary

AHI	Assistant Health Inspector
BARD	Bangladesh Academy for Rural Development
BDRCS	Bangladesh Red Crescent Society
CBD	Community-based Distribution
CC	Community Clinic
CG	Community Group
ESP	Essential Services Package
FIAP	Functional Improvement Action Plan
FPI	Family Planning Inspector
FPMD	Family Planning Management Development
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HA	Health Assistant
HI	Health Inspector
HPSP	Health and Population Sector Programme
ICFHDP	Integrated Community Family Health Development Programme
LDC	Less Developing Countries
LIP	Local Initiative Programme
MO	Medical Officer
MCH	Maternal and Child Health
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
SC	Satellite Clinic
TFIPP	Thana Functional Improvement Pilot Project
UHC	Upazila Health Complex
UHFWC	Union Health and Family Welfare Centre
UP	Union Parishad
UTDC	Upazila Training and Development Centre
VDP	Village Defence Party
VHV	Village Health Volunteer

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Summary

It has been proposed in the Health and Population Sector Programme (HPSP) 1998-2003, adopted by the Government of Bangladesh (GoB), to build a partnership of public-sector facilities and providers with the community to efficiently and effectively address the health needs of the local populations and to ensure long-term sustainability of the essential healthcare provision. The government guidelines on the establishment and operation of the Community Clinics (CC) recommend that a Community Group (CG), comprising the local community leaders and representatives, would play a pivotal role in selecting a site and donation of land for a CC and its repair, maintenance, supervision, and management, including the security. The government would provide the cost of construction of clinic building, and the construction would be done by the government agencies under local supervision of the CG. The government would also supply necessary medicines, equipment, and furniture, and would make available the service providers. Although the GoB guideline depicts, in general terms, the role and responsibilities of CGs in the management of CCs, details of their formation and tenure, how to discharge the entrusted activities, etc. have not been specified in the guideline. It was, therefore, necessary to develop comprehensive operational guidelines for CGs.

The study was, thus, intended to gather community perceptions specifically to: (a) formulate a modus operandi (terms of reference) for CGs, and (b) ascertain the specific activities feasible for CGs to perform and the means through which the community can discharge them. The study followed a qualitative approach of participatory discussion with the CG members and other elected community representatives. During August-December 1999, 6 workshops were held in 6 unions of 4 upazilas (sub-district), namely Abhoynagar and Keshobpur upazilas in Jessore district, and Mirsarai and Sitakunda upazilas in Chittagong district. These workshops were participated by the members of 18 CGs. The participants were enthusiastic in shouldering the responsibilities given to them, and candidly expressed their views and ideas on the matters discussed with them.

A considerable number of participants suggested that the tenure of the CG should be 3 years with a provision for co-option of new members in case of death of any member, inability of a member to function for physical reasons, out-migration, resignation on personal grounds, or termination of one's membership following disciplinary action. The participants opined that the CGs should be made accountable to the UP Chairman, and a collaborative relationship should be built between the CGs and the government health and family planning supervisors. They also shared their opinion on maintenance and security of the clinic building. They further suggested that user fee, donations, and subscriptions could be thought of as the possible mechanisms for community financing. The

workshops with the CG members conducted at the union level provided a unique opportunity to make direct interactions with the CG members, and were highly effective in developing the modus operandi of CGs.

The suggestions put forward by them and the active and positive participation observed in forwarding the suggestions gave an impression that implementation of the strategy of community participation as envisaged in the HPSP may be feasible. Results of the discussion suggest that the CGs should be sufficiently empowered to deal with the desired responsibilities. However, further research is needed to see how effectively the community can continue to shoulder the responsibilities entrusted to them with regard to the management of CCs.

Introduction

Bangladesh, like many other less-developing countries (LDC), is striving against rapid population growth, high rates of maternal and infant mortality and morbidity, low quality of healthcare, and inadequate budget provision for the health and population sector. The problems relating to high-population outcomes, low efficiency of both public and private facilities, and sustainability of the required service provision can hardly be effectively addressed without active participation of the community in the healthcare delivery system.

Arguably, health cannot be separated from the overall socioeconomic conditions of the country. Involvement of the local community in the healthcare system is likely to strengthen the required linkage between the healthcare providers and the community needs and expectations. Thus, community participation has been high on the agenda of health programmes of the government and non-government agencies in Bangladesh, since the Alma Ata Conference in 1978. Nevertheless, a systematic practice of effective community participation in the health sector of the country is yet to achieve.

The Government of Bangladesh (GoB), in its Health and Population Sector Programme (HPSP) 1998-2003, has adopted a precise approach of community participation in managing the health and family planning programmes. This approach outlines the involvement of the community in the management of Community Clinics (CC), in partnership with the government [1]. However, how and to what extent the community involvement and participation can be effectively ensured remains as a challenge, and, thus, merits further study. The present paper focuses on the practical ways and means of institutional participation of the community in the operation and management of primary-level healthcare facilities in the community.

Background

The HPSP is aimed at providing a package of integrated health and family planning services, namely the Essential Services Package (ESP), in an effective and financially sustainable manner. To be responsive to the needs of clients, especially to those of women, children, and the poor, the 5 core components of the ESP are: (i) reproductive healthcare, (ii) child healthcare, (iii) communicable disease control, (iv) limited curative care, and (v) behaviour change communication. In the HPSP, the delivery of ESP has been envisaged to be organized at different levels in a way that it meets the needs of local population in a cost-effective manner, is easy to manage, and is convenient for the clients. One–stop provision of services from the static health centres within the various tiers of the rural health system has been adopted as the principal strategy to this end.

In the rural areas, the ESP has been planned to be delivered at the grassroots level from a static centre, called "Community Clinic", for an average population of 6,000. The CC is the lowest tier of the three-tier ESP delivery system in the rural areas of the country. The delivery of ESP involves reorganization and restructuring of the existing service-delivery strategy from the conventional community-based distribution (CBD), i.e. the home-visitation approach, to an alternative that would ensure service delivery from an array of fixed-sites (static clinics) [1].

The HPSP has proposed to build a partnership of the public-sector facilities and providers with the local community to appropriately attain client responsiveness and long-term sustainability of the government healthcare programmes. It has been seen as an attempt to ensure active participation of the local communities in the organization and management of health programmes. The HPSP guidelines on the establishment of CCs recommend that a Community Group (CG), a committee comprising local community leaders and representatives, would play a pivotal role in the selection of a site, donation of land, repair and maintenance, overall supervision, and ensuring security of a CC. The government inputs in the process of establishing CCs would include the cost of construction of the clinic building, supply of necessary medicines, equipment, furniture, and posting of the service providers. Both government functionaries and CGs are expected to jointly oversee the effective functioning of CCs.

The corresponding government guidelines suggest some specific steps to form a CG. The field-level supervisors and providers, such as Health Inspector (HI) and Family Welfare Visitor (FWV), along with the Assistant Health Inspector (AHI) and Family Planning Inspector (FPI), would establish the first contact with the Chairman of the Union[1] Parishad ((UP), the elected local government body) to facilitate the formation of CG. These activities would be accomplished with the active involvement of the Upazila[2] (sub-district) Health Manager (Upazila Health and Family Planning Officer) and other concerned officials. The CG will work under the overall supervision of the Chairman of the concerned Union Parishad [2]. The composition of the CG has been suggested as follows:

a. The total number of members of a CG will be 7-9, of which at least 2 will be female. The person who donated the land for the CC or his/her representative will be a de facto member of the group.

b. Elected ward members must be included in the group.

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[1] A union is somewhat similar to a county. There are 4,451 unions in Bangladesh, each comprising a population of about 27,000. Each union is again divided into 9 wards that serve as the lowest administrative unit of the local government.

[2] There are 465 upazilas (sub-districts) in 64 districts of the country. Each upazila comprises, on an average, 10 unions and a population of about 270,000.

c. Members from among themselves will elect a president of the group.

d. One of the 2 field-level government providers (Family Welfare Assistant/ Health Assistant) will function as the Member-Secretary without any voting right, and he/she will provide necessary secretarial assistance to the group.

According to the GoB guideline, the Community Group has the following responsibilities:

a. Select a site for the CC, and submit a proposal for the same to the UP for approval.

b. Supervise the construction work of the CC to ensure its timely completion, acceptable standard, and quality.

c. Fix suitable working hours for the CC. The working hours should not be less than 40 hours a week.

d. Provide overall supervision to the clinic activities to ensure that service providers remain present as per the clinic schedule, and provide quality services.

e. Organize daily cleaning of the clinic premises (interior of the clinic building, including the toilet and the adjacent compound), minor repairs as and when required (e.g. replacement of washers of the clinic tubewell and other repair work), supply of fuel for kerosene stoves, payment of electric and gas bills, where applicable, repair of furniture, etc.

f. Conduct long-term maintenance/repair/replacement (e.g. painting of walls, repair of roof, floor, and wall), and mobilize local resources for routine and long-term maintenance and repair work.

g. Ensure the safety and security of the clinic building and all other accessories and equipment.

h. Inform and motivate the local people about the benefits of health, nutrition, and family-planning activities.

i. Meet at least once a month to review issues, such as overall operation of the clinic, maintenance, use of services, quality of services, etc. In addition, the key activities for the next month will be determined at the meeting based on a review of the activities of the current month.

All these have been delineated with the expectation that the local community would actively participate in the organization, planning, operation, supervision, and management of CCs. However, the central question in this regard is to examine the community views in relation to shouldering the responsibilities entrusted to them and to what extent and how these could be attained.

Review of Existing Experience

The rural Bangladeshi community had a tradition of being involved in initiatives, such as building educational institutions, roads, playgrounds, orphanages, mosques, and temples, and creating cultural organizations. Community initiatives for health e.g., building charitable medical dispensary, organizing makeshift camps for management of health hazards during disaster, have also been observed over the period of time.

It becomes evident from review of the existing experiences that community participation always creates positive impact on any health-promotion activities. The initiatives taken by the Bangladesh Red Crescent Society (BDRCS), GTZ Bogra Project, MCH-FP Extension Project and Chakaria Community Health Project of ICDDR,B, Local Initiative Programme of the Family Planning Management Development (FPMD), Thana Functional Improvement Pilot Project (TFIPP), and Intensified Primary Health Care Project of the Ministry of Health and Family Welfare, Bangladesh, are worth mentioning in this respect. The nature of and opportunities for participation by the community range from membership in local-level planning and coordination committees, provision of voluntary labour, and financial and/or material support for project activities, to payment for services through local arrangements and organization and management of various health activities.

The TFIPP facilitated the government health and family planning programme in 55 thanas (at present called upazila) to strengthen the existing health and family-planning service-delivery system in Bangladesh. The main strategy the project followed was to promote a team approach between health and family-planning at both upazila and district levels. The Functional Improvement Action Plan (FIAP) of the TFIPP ensured a decentralized local-level planning process with the involvement of all stakeholders, including the community [3].

As part of the FPMD activities, the Local Initiative Programme (LIP) has been in operation since 1987 to improve the performance of the Bangladesh Family Planning Programme at the grassroots level through strengthening the management capacity of the government (upazila level) family-planning staff and local leaders. The LIP provides ongoing training, monitoring, and technical assistance to the upazila teams and community volunteers. The upazila team consists of upazila-level family planning staff, elected representatives, and community leaders.

The primary health care (PHC)-intensification approach of the Directorate General of Health Services in Bangladesh reorganizes the components of the health and family-planning infrastructure and its activities into a district healthcare system based on primary healthcare. These are: (i) extension of the healthcare system downwards so as to provide basic healthcare at the grassroots level with community participation and intersectoral support; and (ii) development of

functional integration of the health and family-planning personnel and services through formation of Upazila PHC teams [4]. The basic issue of community participation in this approach is addressed by training the village health volunteers (VHVs), selected by the community, who formed a linkage between the government efforts and the people.

The aim of the Chakaria Community Health Project of ICDDR,B, located in Chakaria, Cox's Bazar, is to design and implement sustainable ways of community participation in health matters through indigenous village-based self-help organizations. The project experience suggests that the existing village-based self-help organizations can be activated and sustained to undertake health-related initiatives [5].

The Integrated Community Family Health Development Programme (ICFHDP), Bogra, aims to contribute toward the national goal of improving the health status of the rural population, especially of mothers and children. This model is focused on the integration of government health and family-planning services through community participation. The communities participate in the delivery of health services through village committees and a system of unpaid health and development volunteers.

The general objectives of the Bangladesh Red Crescent Society (BDRCS) Primary Health Care Project are to render community-based healthcare services, with particular emphasis on mother and child healthcare, and improvement of the health status of the community through promoting preventive and curative measures. The community participation component of this Project entails: (i) management improvement through Village Health Committee, Centre Organizing Committee, and organizers' conference with BDRCS authorities in the decision-making process, and (ii) cost-sharing approaches, such as cost-recovery, service charge, and fund-raising, through community mobilization [5].

The *'Jiggasha'* (i.e. to enquire), a community network approach to family planning developed by the Johns Hopkins University Centre for Communications Programme, Bangladesh (currently known as Bangladesh Centre for Communication Programme–BCCP), was based on a community-based interpersonal communication system. The main objectives of the *'Jiggasha'* strategy were to: (i) make field workers more effective to extend their reach by encouraging them to meet groups of women at one site to provide service, discuss or distribute contraceptives, and follow up difficult cases, and (ii) encourage the influential community members (link persons) to promote the benefits of family planning. This approach, through which one field worker could reach many clients at a time, developed volunteers (opinion leaders) as 'link persons' and group members (men and women living in a particular catchment area), who participated in a centre-based family planning and other related health-behaviour change activities. The *'Jiggasha'* provided significant social support that led to

behaviour change, and has achieved considerable success in involving the opinion leaders of the community in family planning programme activities [6].

The community has also been actively participating in the existing government and NGO service-delivery system. The EPI outreach sites and satellite clinics (SCs) are held in the houses and premises selected and offered voluntarily by the community members where the activities of these temporary service outlets are being conducted. The SCs and EPI outreach sites are quite encouraging examples of sharing some responsibilities of healthcare delivery by the local communities.

It can, thus, be concluded that a number of programmes experimented various mechanisms of involving the local community in the service-delivery process. These strategies, by and large, seemed to be conducive to the sustainability of programmes by making the latter client-responsive and community-centred. However, in most cases, these approaches appeared to be much more complex in terms of organization, supervision, and monitoring of their strategies. A high degree of project effort was usually required to establish and operationalize such approaches, ultimately questioning the long-term sustainability, and continuation of the approaches once the projects pursuing these strategies withdrew their support [6].

Objectives of the Study

Although the GoB guidelines depict, in general terms, the roles and responsibilities of CGs in the management of CCs, details on how to discharge the entrusted activities are not specified in the guidelines. As part of the ORP's collaborative operations research with the corresponding GoB agencies on ESP delivery and CCs, a study was undertaken to develop comprehensive operational guidelines for CGs. The study was intended to gather the perceptions of Community Group members specifically to:

a. formulate a modus operandi (terms of reference) for CGs; and

b. ascertain the specific activities that are feasible for CGs to perform and the means through which the community can discharge them.

Research Questions

The study addressed the following research questions to develop the operational guidelines for CGs in managing CCs:

a. What should be the ideal tenure of work of a Community Group?

b. What should be the procedures of forming a new group?

c. When should the membership of a group member be terminated?

d. What should be the procedure of co-opting a new member?

e. How can the group be accountable for its activities?

f. What should be the relationship between a Community Group and government health staff?

g. How should the security of a clinic be maintained?

h. How should cleanliness and day-to-day maintenance of a clinic be ensured?

i. How can a fund for operation of a Community Clinic be generated?

Methodology

The study followed a qualitative approach of participatory discussion with the CG members and other elected community representatives. During August-December 1999, 6 workshops were held in 6 unions of four upazilas, namely Abhoynagar and Keshobpur upazilas in Jessore district, and Mirsarai and Sitakunda upazilas in Chittagong district. These workshops were participated by the members of 18 CGs, community-level health and family planning service providers and concerned union-level supervisors of the government health system. Table 1 shows the schedule of participatory workshops conducted in the study areas. The workshops, organized through the local UPs conducted at the union level, were chaired by the respective UP Chairman.

The participatory approaches were based on the Participatory Rural Appraisal (PRA) technique which enables the local people, rural or urban, to come up with their own appraisal, analysis, action, monitoring, and evaluation regarding specific issues. A brief note on PRA can be seen in the Annexure.

Table 1. Schedule of workshops with Community Groups

No. of workshops (n = 6)	Upazila (n = 4)	Union (n = 6)	No. of Community Groups (n = 18)
2	Abhoynagar, Jessore	Paira	2
		Baghutia	3
1	Keshobpur, Jessore	Mangolkot	4
2	Mirsarai, Chittagong	Dhum	2
		Hinguli	4
1	Sitakundu, Chittagong	Muradpur	3

The participants were first oriented on the newly-reorganized service-delivery approach and their expected roles and responsibilities as envisaged in the GoB guidelines for the establishment and operation of CCs. The briefing also included the rationale of the new approach and the importance of active involvement and participation of the community in the new service-delivery approach. The participants were, then, asked to present their ideas and views on specific activities relating to the areas of discussion. The discussions were aimed at identifying possible answers to the research questions. Opinion expressed on an issue by any of the participants was reviewed by others, and finally a consensus was reached. The discussions concentrated on the issues (Box) relating to the responsibilities to be shared by the community, and the issues relating to constitutional aspects of the group. This exercise followed the concept of "participatory discussion" whereby the government health and family planning supervisors and providers were also invited to attend the workshops. This was done with the intention of forging a better understanding among the key stakeholders of the CC initiative and seeking necessary clarification of the service providers, as required, on the issues discussed.

Box. Issues for discussion with Community Groups

Terms of reference • Tenure of work of the Community Group • Conditions for termination of Community Group membership • Inclusion of new members in the Community Group	• Formation of a new group • Accountability of the Community Group • Relationship with health and family- planning supervisors and managers
Responsibilities • Security of the clinic building and clinic equipment/furniture • Cleanliness and day-to-day maintenance • Resource mobilization/fund generation	• Long-term maintenance • Promotion of the clinic • Overall supervision • Monthly meeting

Workshop Discussions

The workshop participants were found to be quite enthusiastic in shouldering the responsibilities given to them, and candidly expressed their views and ideas on the matters discussed with them. The series of workshops with the CG members

conducted at the union levels proved to be useful in teasing out the community perspectives regarding the research questions.

Sociodemographic characteristics of CG Members

A total of 143 members from 18 CGs attended the workshops. Information on their age, sex, education, and occupation is presented in Table 2. The group members were divided into four groups according to their age. As shown in the table, two-thirds of the members belonged to young age groups (18-45 years). One-third of them represented female members. The vast majority (89%) had primary or above education. All of them, except only one, were employed in some type of income-generating activities. The overall sociodemographic profile indicated that the CGs in terms of age, sex, education, and occupation were quite representative and diverse, and hence, should be able to bring the perspectives of different rural social and demographic groups.

Table 2. Selected sociodemographic characteristics of Community Group members

Background	No. of members (n = 143)	Percentage (%)
Age (years)		
18-30	19	13
30-45	75	53
45-60	39	27
60-75	10	7
Sex		
Male	96	67
Female	47	33
Education		
Within primary level	16	11
Above primary and within secondary level	83	58
Above secondary and within higher secondary level	28	20
Above higher secondary level	16	11
Occupation		
Agriculture	18	13
Service	87	61
Business	20	14
Others*	17	12
Unemployed	1	-

*Include informal sector employment

A. Terms of Reference

What would be the tenure of work and termination factors?

Since the CGs are presumed to play a crucial role in the effective functioning of CCs, it is necessary for the groups to have clearly defined rules on their tenure of work and termination. The participants came up with several options with regard to the tenure of the CG. Some suggested the tenure of a CG should be 2 years, some opted for 3 years and 5 years, while some were in favour of a permanent committee without any timeframe. The majority of the discussants expressed reservation on an extended tenure citing the plausible complications that might arise if the committee works for a too long period. At the same time, it was expressed that a committee needs enough time to achieve its goals. Some participants suggested that the tenure of the CG should be in line with the tenure of the UP, although some others opined that the tenure of the group should be 5 years, irrespective of the tenure of the UP. A considerable number of participants suggested a moderate time period of 3 years. Another option was a 2-year tenure, similar to a school management committee. One proposal was that since the CG is meant for serving the people, there should not be any hard and fast rule about the tenure of its work and termination of its members. It was suggested that the land donor or his/her representative or anyone of the locality contributing a substantial amount of subscription could be considered for inclusion in the Group as its lifetime member.

Several issues were raised with regard to the continuity of membership. It was suggested that the UP Chairman should serve a show-cause notice to the member of the Community Group who would miss to attend 3 consecutive monthly meetings. In general, it was suggested that the membership would be terminated in case of death, physical incapability, out-migration, resignation due to personal reasons, or on disciplinary grounds.

How a new member would be co-opted?

There should be a provision for new member(s) to be co-opted following the death of any member, incapacitating illness, migration, resignation due to personal reasons, or termination for disciplinary reasons. For co-option, the participants suggested that the CG could identify a replacement before placing the matter to the UP Chairman. The process of co-option should be finalized within 60 days. Since the CG will be meeting once a month, 60 days for co-option of a new member seem to be reasonable for completion of the entire process.

How the responsibility would be handed over to a new group?

Based on the discussion, the participants concluded that hand-over of the responsibilities/funds or inclusion of a new member would take place in a

meeting in presence of the UP Chairman and the CG members. Major activities as such can take place in the UP meetings along with all other CG members at an interval of 3 months. Since the CGs would be formed through the UPs, and would be overseen by the UP Chairmen, it was felt that the presence of UP Chairman would authenticate these organizational activities.

After successful completion of the tenure, a new CG should be formed under the supervision of the UP Chairman. Continuation of membership of the CG members should be decided on the basis of their performance.

What should be the mode of accountability of the groups?

Accountability is one of the most important aspects in the functioning of CGs. A CG should perform its activities within well-specified arrangements for accountability. The participants opined that the CG members should be made accountable to the UP Chairman. The UP Chairman should occasionally visit the CCs to ensure that the latter are functioning properly. Furthermore, the participants suggested that the meetings with the UP Chairman should be held at an interval of 3 months or as felt necessary by the UP Chairman. These meetings would give the members an opportunity to discuss all the major activities of the CC with the UP Chairman. In addition, the CGs should share a copy of the minutes of their regular monthly meetings with the UP Chairman. The Chairman would ensure that review of the CC activities is included as a regular agendum of the UP meetings. Some reasons were outlined by the participants behind the suggested process of accountability. The Union Parishad is the primary level of the local government system in Bangladesh, and the UP Chairman is the elected head of that local government body. Since the CG is formed through the UP Chairman, he/she should be considered as an appropriate linkage between the government and the CGs. In addition, the UP is the local authority to generate fund through levies, taxes, etc., and also receives government financial allocation to undertake development activities within the union. It was perceived that the fund generated locally can support a portion of the recurrent and maintenance costs of the clinic. Actually, the UP is the focal point of coordination for all the development activities for the local populace. The government is emphasizing strengthening of the local government institutions, including the UP, as the pivot for development initiatives in the rural areas. Empowering the UP Chairmen to oversee the CGs was seen to well-commensurate with this vision.

How should the relationship with GoB supervisors be maintained?

The participants opined that a collaborative relationship should exist between the CGs and the related health and family-planning union supervisors and upazila managers. Participation of the union-level supervisors (AHI/FPI) in the monthly meetings of the respective CGs was felt necessary to nurture the relationship. They should also be present in the respective UP meetings, where activities of the

CCs would be reviewed, to keep themselves updated of the discussions and facilitate the necessary follow-up work. The CG members expressed concern that the service providers might go on leave without informing the CG, because their leave is officially granted by their supervisors (MO-MCH at UHC). To avoid misunderstanding, it was, however, suggested to inform the CG President about the leave plan of the service providers. It was further noted that there could be a board in the clinic where this information may be displayed.

B. Responsibilities

How to ensure security?

Furniture, equipment, medicines and other commodities, and the clinic building need security support. To ensure the security of the clinic building, UP "Chawkidar," village police, the youngsters of the locality and, above all, the neighbouring households can extend their support. An ambitious proposal was made to appoint a night-guard. The salary of the night-guard was to be covered from a recurrent cost fund to be generated by the CG. It was also suggested to form a Security Sub-Committee to ensure the security of the clinic. The Ansar-Village Defence Party can also be a part of the security scheme with nominal remuneration. It was suggested that the keys of CC should be kept with the providers.

How to ensure cleanliness?

Since there is no provision for any cleaner to ensure routine cleanliness of CCs, the CG has been given the responsibility to take measures on such activity. The CG members suggested the use of the recurrent cost fund to ensure the cleanliness of CCs. The appointed night-guard might also be assigned to clean the CC in the morning, and his salary might be supported from the suggested recurrent cost fund. It was also expressed that the local people might be motivated to offer voluntary labour for this purpose.

How to mobilize resources?

Realizing the fact that some sharing of the related costs would be required, the CGs suggested for mobilizing resources locally for the management of CCs. Running a maintenance fund to meet recurring cost of the clinic was strongly recommended by the participants. It was suggested that the service seekers might contribute Taka 1.00-2.00 as a registration fee (user fee) to the maintenance fund. There is also a scope for the rich to donate. The households of the locality with higher income can pay subscriptions. The Committee can maintain a bank account for the fund, and one of the Group members may act as its treasurer. Particular attention should be given to proper use of this fund. There can be

events (long-term maintenance) that might need a substantial amount of money. In such cases, the groups suggested for the government's assistance.

In one union, the UP Members volunteered to pay subscriptions regularly from their monthly remuneration. Those who cannot pay in cash may always contribute through physical labour. However, it was suggested that the poor should be identified and exempted from paying user fees or any other subscriptions. The CG members noted that they would be able to identify the poor for such exemption. The criteria to be used by the community in identifying the poor and appropriate mechanisms of community financing appeared as important issues of further studies.

Recommendations

It is understandable that the working capability and initiative to be taken by an individual CG might vary. Some groups may perform pretty well, while others may not. Therefore, the study on the basis of the above suggestions developed operational guidelines for the CGs to work in a uniform manner.

A careful review of the suggestions offered by the community members, and the other related experience on community development activities led us to recommend the following for developing a comprehensive, operational guideline (modus operandi) for CGs. These recommendations are the early findings to begin the initiative of participatory management of CCs by the local rural community. Further experience would provide more insights into the related issues and facilitate improvement of the joint management efforts at the local community level.

A. Terms of Reference

Tenure of work

The tenure of a CG should be limited to a maximum period of 3 years from the date of formation of the group. The group will automatically be dissolved on the day it completes its tenure. The new group formed, following the primary criteria, will replace the old group. The working period of the CG should be independent of the tenure of the UP. No change should be made, even if a change in the UP office occurs during the period of a CG's tenure. An independent tenure may allow the group to work relatively free from any socio-political influence relating to the local government and local political institutions. Additionally, a 3-year timeframe may be enough for the committee to achieve its goals.

Formation of a new Community Group

A new group will be formed as soon as the previous one completes its tenure. Following the GoB guideline, the UP chairman will form the new group. The guideline should be discussed at the UP meeting, and the selection of the group members should be approved in the UP meeting. The CC providers and supervisors will assist the UP chairman in forming a new group in consultation with the local community. The community may decide to select any of its members from the earlier group considering his or her contributions during the tenure of the previous group. The hand-over of responsibilities/funds would take place at a meeting in presence of the UP Chairman and the CG members.

Termination of membership

In general, membership will be terminated in the case of death, physical incapability, migration, or resignation due to personal reasons, and after completion of tenure. Membership may also be terminated due to disciplinary reasons, such as misappropriation of funds and missing 3 consecutive monthly meetings. Failure to attend 3 CG monthly meetings in a row should be considered as lack of interest of the concerned member.

Inclusion of new members

Provision should be made for co-option of new members following the cessation of membership of any member due to reason(s) stated above. Inclusion/co-option of a new member should take place in a CG meeting, preferably in presence of the UP Chairman. The co-option of a member should be discussed in the UP meeting, and should be approved by the UP Chairman. For co-option, the CG can identify the replacement before placing the matter to the attention of the UP Chairman. The process of co-option or new inclusion must be completed within 60 days of vacating any membership.

Accountability of the Community Group

The CGs should be made accountable to the UP. As an elected community representative and the head of the local government body, the UP Chairman may be assigned as the functional supervisor of CGs, and should also act as the advisor of the groups within the union. The group will keep the UP Chairman updated through a copy of the minutes of its monthly meetings, which should include the performance status of CCs. The UP Chairman should also regularly visit the clinics to ensure that services are appropriately provided. Furthermore, there should be meetings with the UP Chairman at an interval of 3 months or as felt necessary by the Chairman to facilitate proper implementation of the objectives of CCs. These meetings would provide an opportunity for members to discuss all

major activities of CCs with the UP Chairman. A review of the activities of CCs should, thus, evolve as a permanent agenda item of the UP meetings.

Relationship with health and family-planning providers and managers

Participation of the union-level supervisors (AHI/FPI) at the monthly meetings of the respective CGs is necessary to nurture the relationship. They should also be present at the respective UP meetings. The Upazila Managers may also be invited to participate in the quarterly meetings of the UP, where the issues relating to service-delivery and the performance of the providers may be reviewed.

The CG should be duly informed about the leave of absence of any CC providers. Any action by the upazila management relating to service-delivery, management, or logistics of the CCs should be communicated formally to the CG through distribution of a copy for information of the President of the group. Vice versa, the CGs should also keep the Upazila Managers informed about the outcome of the monthly meetings and quarterly review meetings through circulation of the minutes of the meetings.

B. Responsibilities

Security of the clinic building

A security sub-committee may be formed with representatives from among the members, neighbouring households, and the youngsters of the locality to ensure the security of the clinic. The UP Chowkidar and Ansar-VDP members can also be part of the security sub-committee. The CG may be allowed to recruit a night-guard, whose salary can be paid from the recurrent cost fund of the group.

Cleanliness and day-to-day maintenance

The appointed night-guard may also be assigned to ensure cleanliness of the clinic in the morning, and his salary may be supported from the recurrent cost fund. The local people should as well be encouraged to volunteer physical labour for the purpose routinely or in special occasions. Any other day-to-day expenditure may be met from the same fund.

Resource mobilization

The following actions may be taken to generate and maintain a fund for the operation and maintenance of CCs:

a. Service-seekers may be charged Tk. 1.00 -Tk. 2.00 as registration/user fee.

b. The CG can collect regular subscriptions from the well-to-do households of the locality. The rich may also be approached for a lump-sum donation to the clinic.

c. Those who can not pay in cash may be approached to contribute physical labour.

d. The poor, however, should be exempted from paying user fee or any subscription.

e. An endowment fund may be created to accept voluntary donations.

f. The group should maintain a cash register and a bank account for maintaining these funds.

Conclusion

Bangladesh has had experience of reasonable level of success of community participation in the héalth and family-planning programmes. The importance of community participation in the HPSP has also been underscored and according to the HPSP, the community should play an active role in the management of the rural CCs in partnership with the government throughout the country. This study made an effort to work out the operational guidelines for the government-community partnership for the CCs. It is, however, in future to see, when the CCs would be fully functional, how effectively the community can participate in the CC-based health programmes and shoulder the entrusted responsibilities. The study experience indicates that it would be useful to organize some training programmes at the local level for the CG members for developing their managerial skills to help them discharge the desired responsibilities appropriately.

The methodological tool - "participatory discussion" - used for getting suggestions from the community on their own involvement in the management of CCs, was found to be useful for the study. Providing a platform for the community to express their own opinions was also found to be useful in developing these guidelines. It is well understood that the greatest factor in improving the health status of the community and its sustenance is the active participation of the community people. As the process of implementing the new ESP service-delivery systems will proceed, many new priorities are expected to emerge. For example, the viable mechanisms of community financing of CCs and revenue-management procedures, easy-to-implement and effective criteria for identification of the poor may come out as an effective guideline for other programmes too. These issues are quite challenging, and deserve special attention of the researchers and policy-makers. The equity aspects of the CC-based service-delivery both in terms of socioeconomic status and gender are also critical to assess the effects of the new service-delivery systems.

Also, the challenge that remains ahead is to develop a sustainable health programme. One major factor in programme sustainability is that the programme be managed and financially supported by the local community. The community group needs to be adequately empowered to provide such support. Hence, the strategy of building an effective partnership between government resources and the local community in the organization and management of the health services will need to address many more critical issues. However, one issue emerged quite apparently from the study. Local communities are highly supportive to such initiative, and adoption of appropriate measures should result in a sustainable government-local people partnership in the provision of ESP.

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Participatory Rural Appraisal (PRA)

Participatory Rural Appraisal (PRA) is the label which has been attached to a growing family of relaxed approaches and methods which enable the local people to make their own appraisal, analysis, and plans, to share information, to act and to monitor and evaluate actions and programmes.

PRA has been evolved from and draws on many sources, including participatory action research, applied social anthropology, agro-ecosystem analysis, field-research on farming systems, and rapid rural appraisal (RRA). RRA developed and spread in the late 1970s and 1980s as a reaction against the biases of rural development tourism (the brief rural visit of the urban-based professional) and the distortions, costs, and inefficiencies of questionnaire surveys.

RRA and PRA share the principles of learning from and with people, directly, on site and face to face, learning rapidly and progressively, offsetting bias, optimizing trade-off between quantity, relevance, accuracy and timeliness of information, triangulating (cross-checking) and seeking diversity.

The purpose of RRA is learning by outsiders. Many practitioners insist that PRA is different: Its aim is to facilitate appraisal and analysis by local people themselves. We outsiders enable them to do many of the things we thought only we could do.

PRA has three pillars--methods, behaviour and attitudes, and sharing. Of these, "behaviour and attitudes" is the most important. PRA stresses: unlearning; self-critical awareness and responsibility, embracing error, "handing over the stick", having confidence that they can do it; being nice to people, sitting down, listening, learning and not interrupting; patience and not rushing; and using one's own best judgement at all times. PRA derives much of its strength from emphasizing:

- open-ended enquiry
- visualization (maps, matrices, diagrams, models)
- comparisons
- analysis by groups.

RRA methods, such as semi-structured interviewing, are also used to PRA. In addition, PRA facilitates much the use of relatively new methods in a participatory way, such as:

- participatory mapping and modeling
- transact walks and observation
- seasonal calendars
- timelines and trend
- matrix scoring and ranking
- wealth and well-being ranking and grouping
- institutional diagramming
- analytical diagramming.

MCH-FP Extension Work at the Centre

In 1982, the MCH-FP Extension Project with funding from USAID began to examine in rural areas how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first year, the Extension Project set out to replicate workplans, and record-keeping and supervision systems, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants. Other successful programme strategies scaled-up or in the process of being scaled-up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, management information systems, and strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, the project started family planning initiatives in Chittagong, the lowest performing division in the country.

The Centre and USAID, in consultation with the government through the Project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-1997. Salient features include: improving management, quality of care and sustainability of the MCH-FP programmes, and providing technical assistance to GoB and NGO partners. In 1994, the Centre began an MCH-FP Extension Project (Urban) in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers in international scientific journals.

In August 1997 the Centre established the Operations Research Project (ORP) by merging the two former MCH-FP Extension Projects. The ORP research agenda is focussed on increasing the availability and use of the high impact services included in the national Essential Services Package (ESP). In this context, ORP has begun to work with partners in government and NGOs on interventions seeking to increase coverage in low performing areas and among underserved groups, improve quality, strengthen support systems, enhance financial sustainability and involve the commercial sector.

ORP has also established appropriate linkages with service delivery partners to ensure that research findings are promptly used to assist policy formulation and improve programme performance.

The Division

The Health and Population Extension Division (HPED) has the primary mandate to conduct operations research, to disseminate research findings to programme managers and policy makers and to provide technical assistance to GoB and NGOs in the process of scaling-up research findings to strengthen the national health and family planning programmes.

The Division has a long history of solid accomplishments in applied research that focuses on the application of simple, effective, appropriate and accessible health and family planning technologies. HPED has built up a considerable body of research and constituted the established operations research element for child and reproductive health in the Centre. The Operations Research Project (ORP) provides the Division with a strong group of diverse expertise and disciplines to significantly consolidate and expand its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. For one, the public health research activities of the Division are focused on improving programme performance which has policy implications at the national level and lessons for the international audience also. Secondly, HPED incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructure, dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.

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